SCHEDULE 2 – THE SERVICES

A. Service Specifications

1. Service name	Specialist Allergy Services (Adults)
2. Service specification number	B09/S/b
3. Date published	16/10/2025
4. Accountable Commissioner	NHS England https://www.england.nhs.uk/commissioning/spec-services/npc-crg/blood-and-infection-group-f/specialised-immunology-and-allergy-services/ Email: *england.npoc-bloodandinfection@nhs.net*

5.	**Population and/or geography to be served**
5.1	**Population covered** This service specification relates to adults aged 18 years and over. Young people aged 16 or 17 years old can receive developmentally appropriate care in adult specialised allergy services.
5.2	**Minimum population size** Specialised allergy services provide services for adults with severe allergic conditions or those who have common allergic conditions for which conventional management has failed and for whom specified specialist investigations and treatments are required. Specialised allergy services are provided by multidisciplinary teams, led by physicians with evidence of training and/or experience in the practice of allergy or immunology. An estimated 20 million people in the UK – a third of the population – have an allergy related disorder, although only a proportion will have allergic disease of sufficient complexity to require specialist opinion or management.
6.	**Service aims and outcomes**
6.1	**Service aims** Specialised allergy services deliver high quality, multi-disciplinary specialist care to adults with severe and complex allergies. They aim to reduce morbidity and

mortality from causes considered preventable and improve the experience and health-related quality of life (QoL) of service users with allergic and related conditions.

The above aim will be achieved by:

- Delivering the expertise required for the investigation, clinical assessment and management of service users with suspected and established allergic diseases;

- Integrating care with primary, secondary, and other care providers with particular emphasis on supporting care provision through primary care;
- Promoting prevention strategies, optimising early management of complications, preventing disease progression and reversing previous psychological damage and disability when possible;
- Delivery of safe and effective curative or disease modifying treatments (for example allergen immunotherapy) where indicated and avoiding complications of treatment;
- Developing approaches for the successful lifelong management of allergic disease, including self-management/home therapy;
- Delivering care holistically, ensuring that all service users have access to a wide range of specialist multi-disciplinary services;
- Delivering treatment and care that conforms to UK/European standards and published clinical guidelines;
- Maintain close links with other expert centres at national and international levels;
- Working with relevant stakeholders and service user support initiatives.

6.2 Outcomes

NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill-health or following injury
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm

Service defined outcomes/outputs

There are currently no quality outcomes for this service, however a range of quality metrics are provided with regular data collections which support an enhanced understanding to the quality of the service delivered.

As relevant outcome/impact measures are developed the specification will be updated.

	The full definition of the quality outcomes and metrics together with their descriptions including the numerators, denominators and all relevant guidance will be accessible at https://www.england.nhs.uk/commissioning/spec-services/npc-crg/spec-dashboards/ following the next scheduled quarterly refresh of the dashboard metadata document All centres should be registered and actively working towards or have achieved accreditation through the Royal College of Physicians Improving Quality in Allergy Services (IQAS) programme. Centres that are not yet accredited must have a Trust action plan demonstrating progress towards accreditation. Accreditation involves evaluating a service against a set of standards to promote a culture of continuous improvement, thereby providing assurance to service users, referrers and commissioners about the quality of the service provided.
7.	**Service description**
7.1	**Service model** The following allergic and related conditions will be assessed and managed in specialised allergy centres: **1. Anaphylaxis** a. All causes **2. Food allergy** a. Food allergy to one or more food group with features consistent with IgE-mediated (type I hypersensitivity reactions). In the case of a single food allergy, provision of advice and guidance only may be appropriate. b. Food allergy to a single food/food group where there is diagnostic uncertainty. c. Food allergy with asthma. d. Complex food allergy to a wide range of cross-reacting foods (due to pan-allergens). e. Food allergy where there may be co-factor modification. f. Food allergy where there may be indication for specialised treatment including commissioned/NICE approved novel therapies such as biologics and/or food immunotherapy (initiation and follow-up). g. Food allergy with other severity modifier (see note 2 below). **3. Rhinitis and conjunctivitis/rhinosinusitis** a. Allergic rhinoconjunctivitis requiring allergen specific immunotherapy. b. Rhinosinusitis with recurrent nasal polyps or NSAID-exacerbated respiratory disease (NERD). c. Allergic rhinitis and conjunctivitis with severity modifier (see note 2 below). **4. Drug and vaccine allergy** a. Investigation and management (including skin testing, drug challenges and desensitisation) of suspected allergy to antibiotics, analgesics (NSAIDs, opioids), anaesthetics, contrast media, biologics, antiseptic agents, vaccines where there is a severe presentation (such as anaphylaxis or severe non-immediate cutaneous reaction e.g. drug reaction with eosinophilia and

systemic symptoms-DRESS, Stevens-Johnson Syndrome-SJS, toxic epidermal necrolysis-TEN, acute generalised exanthematous pustulosis-AGEP). The management of service users with severe non-immediate cutaneous reactions is provided by specialised allergy/immunology and/or dermatology services. The lead clinician will vary at different centres, but specialist allergy input should be readily available.

b. Other presentations may be considered for assessment/management depending on specific circumstances, for example:
    i. allergy to multiple antibiotic classes or to beta-lactams in service users highly likely to require these treatments;
    ii. reactions to NSAIDs with asthma or severe angioedema;
    iii. suspected allergic reactions (in addition to anaphylaxis) during general anaesthesia;
    iv. Suspected allergic reactions to local anaesthetics;
    v. Suspected allergic reactions to other medication considered essential for the service user's management where no alternatives are available.

c. Excludes ACE inhibitor-induced angioedema and service users with penicillin allergy label who would be suitable/meet criteria for de-labelling by non-specialised services (see section 7.3 Clinical Networks).

5. Hymenoptera venom allergy

a. All systemic reactions.
b. Excludes large local reactions (LLR) to venom, apart from first assessment when this cannot be unequivocally determined based on referral information.

6. Latex allergy

a. All immediate (IgE-mediated) allergy.

7. Severe multi-system allergic disease (including but not limited to service users with asthma, allergic rhinoconjunctivitis, atopic eczema, and possible food allergy).

8. Chronic urticaria and/or angioedema

a. Chronic spontaneous (CSU) or inducible (CIndU) urticaria and/or angioedema not controlled with maximum standard therapy as per current guidelines and CSU/CIndU requiring treatment with commissioned/NICE approved options including biologics and available novel therapies. ICB commissioned treatments available to non-specialised services must also be available to specialised services via local commissioning arrangements.

9. Mastocytosis and related disorders

a. The management of service users with mastocytosis is provided by specialised allergy/immunology, dermatology and haematology services. The lead clinician will vary at different centres, but specialist allergy input should be readily available.
b. Service users with symptoms attributed to Mast Cell Activation Syndrome (MCAS) will only be assessed in specialised allergy services when the Vienna Criteria for MCAS (see appendix 1) are met or criteria elsewhere in this service specification are met.

10. Gastrointestinal allergic diseases (service users with gastrointestinal allergic diseases should be managed through a multi-disciplinary approach working with the gastroenterology teams)

a. Eosinophilic GI disease.
b. Food Protein-Induced Enterocolitis Syndrome.

11. Hypereosinophilic disorders

a. Hypereosinophilic disorders with severity modifier is managed predominantly in a subset of specialised centres by specialist allergy/immunology, haematology, dermatology, rheumatology and gastroenterology services. The lead clinician will vary at different centres, but specialist allergy input should be readily available.

12. Hereditary or acquired angioedema

a. Provided by a subset of specialised allergy services and mainly by immunologists (see service specification for specialist immunology services for adults with deficient immune systems), with whom specialist allergists should be working closely.

Note 1

Anaphylaxis is a serious systemic hypersensitivity reaction that is usually rapid in onset and may cause death. Severe anaphylaxis is characterized by potentially life-threatening compromise in airway, breathing and/or the circulation. In most cases, there are associated skin and mucosal changes.

Note 2

Inclusion Criteria

Individuals requiring specialised allergy services would be characterised by:

- Increased risk of death because of severity of the allergy;
- Persisting poor quality of life despite routine therapies with restrictions to daily activities at home and/or at work including those with severe allergic rhinoconjunctivitis, chronic urticaria, severe eczema/atopic dermatitis with a major allergic component (managed in collaboration with dermatology services) and with allergic asthma (in conjunction with respiratory services);
- Rare diseases leading to allergic symptoms requiring complex investigations and therapies (mastocytosis, hereditary angioedema, eosinophilic enteropathies and other hypereosinophilic diseases).
- Diseases with allergic symptoms but where the cause is unclear (idiopathic) and specialist input is required to make a specific diagnosis, identify triggers, optimise management and prevent further recurrences.

Specialised services should provide access to all commissioned treatments for allergic disease including licensed allergen immunotherapy. Subcutaneous immunotherapy should only be performed by experienced health care professionals in specialised commissioned allergy centres with direct access to resuscitation facilities. Sublingual immunotherapy (SLIT) should be initiated in specialised commissioned allergy centres or by other secondary care services with appropriate expertise to manage patients with allergic disease, with shared care agreements involving primary care for ongoing treatment.

Exclusion Criteria

- Non-specific symptoms, such as those attributed to chronic fatigue syndrome or multiple chemical sensitivity without evidence of allergy.

	• Diagnosis of allergy using scientifically unproven tests or investigations without symptoms consistent with inclusion criteria above. • Pruritus without a rash. • Contact dermatitis (allergic or irritant) not meeting the definition of 7 above. • Food intolerance. *Exit Criteria* Service users will leave the service when: • their allergic disease is controlled and suitable for self-management or management by non-specialised allergy services or primary care physicians; • their allergen immunotherapy course is completed and no further follow-up is indicated. Hours of operation The Provider must ensure that services are available Monday to Friday from 09:00 to 17:00 hrs. The Provider must ensure that pathways for out of hours access to appropriate emergency care are locally agreed and that service users are aware of the arrangements. Services should work collaboratively with urgent care services to provide guidance for the management of users of the specialised allergy service should they present acutely. Health inequalities statement Services should be organised on a population health basis with a clear referral and treatment pathway to ensure that people with suspected or diagnosed allergic conditions: • have equitable access to specialised allergy outpatient and inpatient services for the purposes of diagnosis and management; • have equitable access to commissioned treatments for allergic conditions; • have care provided as close to home as possible, with appropriate governance and oversight where necessary from multi-disciplinary teams linked to a specialised allergy centre; • have access to clinical trials and research in an equitable manner through engagement with Clinical Research Networks. Services must: • identify which populations currently experience inequitable access with particular reference to deprivation, ethnicity and inclusion health groups; • identify barriers to access at service level for these populations; • implement inclusion measures to improve equity. Wherever any component of the core service specification cannot be delivered at a specialised allergy centre, arrangements should be put in place with other providers of that specialised service to ensure service users continue to have equitable access to treatment.

7.2	**Pathways** Overall patient pathway Referrals for service users presenting with the conditions listed in 7.1 above come from primary care, accident and emergency departments and secondary/tertiary hospital settings. All referrals should be triaged by a member of the specialist team to ensure the referral requires specialist input. A care pathway with referral guidance and advice and guidance should be developed using existing NHS platforms. Specialised patient pathway **Diagnosis** The Provider must deliver a diagnostic package for the investigation of suspected allergic diseases, including specialist allergy tests, food/drug provocation challenges, and respiratory/ENT investigation. There must be documented consent before undertaking drug or food provocation and intra-dermal tests. Specifically this will require: • Skin testing using drugs/food/venom/latex (skin prick/intradermal); • Access to anaesthetic expertise in the investigation of perioperative allergy (e.g. joint clinic or involvement of an anaesthetist as part of a multi-disciplinary approach); • Component-resolved and other in-vitro specialist diagnostic testing; • Allergen challenges including drug, food or other allergen challenges; • Access to methods to investigate allergen-induced asthma including non-specific bronchial challenge with methacholine, mannitol or histamine to define airway hyper-responsiveness, or methods to measure airway inflammation such as exhaled NO and induced sputum where necessary; • Access to bronchoscopy services for investigation of difficult-to-treat asthma; • Access to a comprehensive assessment of the upper airway for service users with resistant rhinitis, including a clearly defined referral pathway for patients with upper-airway asthma mimics (e.g. laryngeal dysfunction); • Access to endoscopy services for service users with eosinophilic enteropathies; • Access to radiology; • Access to diagnostics for rare and emerging allergic diseases through European/USA laboratories; • Access to molecular techniques to diagnose myeloproliferative disorders involving eosinophils and mast cells including a full range of fungal IgE testing, parasite serology, T-cell phenotyping, radiology including CT scan and cardiac MRI, EMG studies, bone marrow examination and advanced molecular detection of c-kit and other mutations associated with

mastocytosis/clonal mast cell disorders, myeloproliferative and hypereosinophilic syndromes.

Treatment and monitoring

The Provider must deliver hospital-based outpatient and day-care with access to inpatient facilities in order to deliver treatments for the conditions listed in 7.1 above. These include:

- Immunotherapy (licensed and commissioned treatments should be offered) for inhalants and Hymenoptera venom allergy– hospital-based injected allergen and home-based treatment via oral or sublingual immunotherapy or other routes. This includes treatment initiation, maintenance and follow-up care;
- Immunotherapy for food allergy - hospital- and home-based allergen treatment via oral, sublingual, epicutaneous immunotherapy or other routes. This includes treatment initiation, maintenance and follow-up care;
- Drug desensitisation;
- Commissioned/NICE approved biologics and novel therapies.

Outpatient care should be provided during weekday working hours, with sufficient clinic numbers and staff to accommodate the service user cohort within clinically appropriate timeframes and maintain IQAS accreditation. As a minimum this will comprise:

- Adequate staffing and clinic space for regular face-to-face and remote outpatient clinics for assessment and follow-up. The service must have the capacity to review service users in a dedicated allergy clinic face-to-face when clinically indicated;
- Access to urgent allergy review where clinically indicated e.g. allergy assessment during pregnancy and when urgent treatment is required;
- Adequate space for service users receiving infusions or training;
- Access to an appropriately staffed designated day case unit where food/drug challenges and desensitisation, drug skin testing, commissioned/NICE approved immunotherapy and biologic/novel treatments can be provided. Staff within the unit should be working to national and international guidelines and IQAS standards;
- Written information for service users and other healthcare providers involved in their care detailing their diagnosis, treatment and monitoring plan.

The Provider must offer service users self-care as an option in their management based on their wishes, abilities and circumstances including:

- Training for the administration of rescue medication at home;
- Provision of information about when to seek advice for new or severe symptoms suggestive of poor control, new sensitivities or increased risk of severe reactions;
- Competency training (for example in use of adrenaline auto-injector devices);
- Provision of home therapy should be offered as an option, where clinically appropriate, as a package of care on a named service user basis. Services

must provide nursing supervision, arrangements for deliveries of consumables to service users' homes, regular outpatient consultations and ongoing monitoring including tests;
- The Provider must ensure that all home care programmes are working to IQAS home therapy standards.

The service should provide support to other clinical specialties for diagnostic and advice queries and support for complications of severe and multisystem allergic diseases.

The Provider should maintain a strong liaison with service user groups involved in allergic disorders to enable further community support and continuity of care.

Clinical governance and audit
The Provider should ensure participation in regional and national allergy audits, specifically based on BSACI and NICE guidance or related national specialty body.

Service user and carer information
The Provider should offer (in collaboration with service user organisations where they exist):
- Written disease-specific information leaflets;
- Periodic educational events for service users;
- Periodic educational events for GPs;
- Information to service users and staff about service user support organisations.

<u>Shared care arrangements</u>

Service users with complex allergy will often be managed by a multi-disciplinary team including ENT, respiratory medicine, gastroenterology, haematology, immunology and dermatology, with specialist allergy nurses, allergy dieticians, allergy psychologists and laboratory diagnostic support providing comprehensive management. Where services are best delivered through joint-speciality clinics (e.g. with severe multi-system allergic or severe asthma, severe eczema disease), these clinic designs should be used.

Care plans and clinic letters should be shared with primary care and other specialities involved in the care of the service user.

Specialised allergy services should enable shared care with other allergy services and with primary care, for example for SLIT for allergic rhinitis/rhinoconjunctivitis. Appropriate training and governance arrangements should be led by specialised allergy services in order to facilitate formal shared care agreements as follows:
- The provision of SLIT through these agreements should be initiated in specialised commissioned allergy centres or by other secondary care services with appropriate expertise to manage patients with allergic disease. Service user monitoring and prescribing can be transferred to

	local hospitals/primary care once service users have been treated without reactions/side effects and their SLIT dose has been optimised and stabilised; • The initial treatment, up-dosing where applicable and initial maintenance dose must be prescribed by the initiating specialist; • Specialised centres should ensure specialist input is available in order to determine duration of treatment, dose or formulation adjustments, frequency of review and decision to terminate treatment. <u>Transition</u> All healthcare services are required to deliver developmentally appropriate healthcare to service users and families. Children and young people with ongoing healthcare needs may be required to transition into adult services from children's services. Transition is defined as a 'purposeful and planned process of supporting young people to move from children's to adults' services. Poor planning of transition and transfer can result in a loss in continuity of treatment, service users being lost to follow up, service user disengagement, poor self-management and inequitable health outcomes for young people. It is therefore crucial that adult and children's NHS services, in line with what they are responsible for, plan, organise and implement transition support and care (for example, holding joint annual review meetings with the child/young person, their family/carers, the children's and adult service). This should ensure that young people are equal partners in planning and decision making and that their preferences and wishes are central throughout transition and transfer. NICE guidelines recommend that planning for transition into adult services should start by age 13-14 years at the latest, or as developmentally appropriate and continue until the young person is embedded in adult services. Specialised allergy services should have formalised arrangements for transition care including: • A named adult allergy consultant in every tertiary centre as designated transition lead; • The adult allergy transition lead or nominated adult allergy team member will engage with paediatric counterparts for pathway and resource development for appropriate transition to adult services (including involvement in any transition documents and resources such as Ready-Steady-Go templates, transition checklist, comprehensive transition letter, joint transition clinic where appropriate).
7.3	**Clinical Networks** All Providers will be required to participate in a networked model of care, including engagement in national/regional MDTs, audits and the development of clinical guidance. These networks should include medical staff, nurses, clinical scientists,

	dietitians, clinical psychology and other allied health professionals providing allergy care in the region. The Provider should actively participate in regional network clinical meetings to review and compare practice and share expertise in these rare conditions. There should be clinical representation from all staff groups at all network meetings (a minimum of three meetings should be held per annum per network). These networking arrangements should aim to provide a clinical governance forum with CPD for the network specialist doctors, specialist nurses and primary care clinicians, including mortality and morbidity review; discussion on local, regional and national issues with regard to allergy and immune deficiency commissioning; creation and alignment of referral and management protocols for common allergic conditions and development of regional experts for specific rare diseases. Where non-specialised services are involved in the diagnosis of allergic disease and initiation or maintenance treatment for allergic disease, specialised centres must provide networking opportunities including support for training and governance.

7.4	**Essential Staff Groups**
	
	Specialised allergy services will be delivered by a multi-disciplinary team due to the complex nature of the conditions. This must include:
	• At least two Consultants* in Allergy or Allergy and Clinical Immunology on the specialist register for allergy or immunology or with evidence of equivalent experience/training in the management of service users with complex/specialist allergy as described above. These Consultants must maintain up to date Continuing Professional Development (CPD) in specialist allergy;
	• At least two allergy specialist nurses*;
	• Access to the following allied health professionals:
	  ○ Dieticians, ideally who have training or specialist experience in the practice of allergy;
	  ○ Clinical psychologists, ideally with expertise in allergic conditions and wherever possible embedded within the service;
	  ○ Speech and language therapists;
	  ○ Lung physiologists;
	  ○ Pharmacists.
	• Access to social workers as required;
	• Investigation of perioperative anaphylaxis should include an anaesthetist within the multi-disciplinary team, with a minimum of at least 20 referrals per annum.
	
	All medical and nursing staff should attend at least two network meetings per annum.

<table>
<tr><td></td><td>* Services should not be organised around a single-handed consultant or specialist nurse model unless fully supported by network governance structures including cover for leave, weekly MDTs and regular network meetings, as well as all other requirements outlined in this document.</td></tr>
<tr><td>7.5</td><td>Essential equipment and/or facilities

Specialised allergy services must have access to the following facilities:
Immediate access to cardio-respiratory resuscitation equipment/team and intensive care facilities;
Dedicated outpatient and day case facilities for the provision of outpatient clinics, skin testing, food/drug challenges, commissioned/NICE approved immunotherapy, food and drug desensitisation and biologics and novel therapies;
Access to an immunology laboratory service with United Kingdom Accreditation Service (UKAS) accreditation or equivalent providing a comprehensive range of immunological investigations;
Accessible facilities for the assessment of lung function;
Access to skin prick testing and intradermal testing facilities.</td></tr>
<tr><td>7.6</td><td>Interdependent Service Components – Links with other NHS services

Allergy specialists must liaise closely with colleagues in a range of specialties based on clinical need including paediatrics, respiratory medicine, ENT, dermatology, haematology, oncology, infectious diseases/microbiology, gastroenterology, ophthalmology, rheumatology, anaesthetics, clinical genetics, behavioural medicine and maternity services.

<table>
<tr><th>Interdependent Service</th><th>Relevant Service Specification/Standards</th><th>Proximity to service</th></tr>
<tr><td>Paediatric Medicine: Specialised Allergy services</td><td>https://www.england.nhs.uk/wp-content/uploads/2013/06/e03-paedi-medi-allergy.pdf</td><td>Same region</td></tr>
</table>
</td></tr>
<tr><td>7.7</td><td>Additional requirements

None</td></tr>
<tr><td>7.8</td><td>Commissioned providers

The list of commissioned providers for the services covered by this specification will be published in due course.</td></tr>
<tr><td>7.9</td><td>Links to other key documents

Please refer to the https://www.england.nhs.uk/publication/manual-for-prescribed-specialised-services/ for information on how the services covered by this specification are commissioned and contracted for.</td></tr>
</table>

Please refer to the https://www.england.nhs.uk/commissioning/spec-services/key-docs/#id-rules tool for information on how the activity associated with the service is identified and paid for.

Please refer to the relevant Clinical Reference Group https://www.england.nhs.uk/commissioning/spec-services/npc-crg/ for NHS England Commissioning Policies which define access to a service for a particular group of service users.

1. **Relevant National Service Frameworks and Government papers/guidance**
   - 1.1. Long term conditions: https://www.gov.uk/government/publications/quality-standards-for-supporting-people-with-long-term-conditions
   - 1.2. UK Rare Diseases Framework: https://www.gov.uk/government/publications/uk-rare-diseases-framework
   - 1.3. Major conditions strategy: case for change and our strategic framework: https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2
   - 1.4. Allergy guidance for schools: https://www.gov.uk/government/publications/school-food-standards-resources-for-schools/allergy-guidance-for-schools
   - 1.5. MHRA - Adrenaline auto-injectors (AAIs): new guidance and resources for safe use: https://www.gov.uk/drug-safety-update/adrenaline-auto-injectors-aais-new-guidance-and-resources-for-safe-use
   - 1.6. MHRA - Adrenaline Auto-Injectors (AAIs): https://www.gov.uk/government/publications/adrenaline-auto-injectors-aais-safety-campaign/adrenaline-auto-injectors-aais
   - 1.7. Food labelling: giving food information to consumers, including allergen labelling: https://www.gov.uk/guidance/food-labelling-giving-food-information-to-consumers

2. **National Guidelines for Allergic Disorders from NICE - National Institute for Health and Care Excellence (NICE) (http://www.nice.org.uk/)**
   - 2.1. Anaphylaxis: assessment and referral after emergency treatment - Clinical guideline [CG134]: https://www.nice.org.uk/guidance/cg134
   - 2.2. Anaphylaxis - Quality standard [QS119]: https://www.nice.org.uk/guidance/qs119
   - 2.3. Drug allergy – Quality standard [QS97]: https://www.nice.org.uk/guidance/qs97
   - 2.4. Drug allergy: diagnosis and management - Clinical guideline [CG183]: https://www.nice.org.uk/guidance/cg183
   - 2.5. Food allergy – Quality standard [QS118]: https://www.nice.org.uk/guidance/qs118
   - 2.6. Food allergy in under 19s: assessment and diagnosis - Clinical guideline [CG116]: https://www.nice.org.uk/guidance/cg116
   - 2.7. Omalizumab for treating severe persistent allergic asthma - Technology appraisal guidance TA278: https://www.nice.org.uk/guidance/ta278

2.8. 12 SQ-HDM SLIT for treating allergic rhinitis and allergic asthma caused by house dust mites – Technology appraisal TA1045: https://www.nice.org.uk/guidance/ta1045

2.9. Palforzia for treating peanut allergy in children and young people - Technology appraisal guidance TA769: https://www.nice.org.uk/guidance/ta769

2.10. Budesonide orodispersible tablet for inducing remission of eosinophilic oesophagitis - Technology appraisal guidance TA708: https://www.nice.org.uk/guidance/ta708

2.11. ImmunoCAP ISAC 112 for multiplex allergen testing - Diagnostics guidance [DG24]: https://www.nice.org.uk/guidance/dg24

2.12. Cryotherapy for chronic rhinitis - Interventional procedures guidance [IPG771]: https://www.nice.org.uk/guidance/ipg771

2.13. Intranasal phototherapy for allergic rhinitis - Interventional procedures guidance [IPG616]: https://www.nice.org.uk/guidance/ipg616/chapter/1-Recommendations

2.14. The Airsonett temperature-controlled laminar airflow device for persistent allergic asthma - Medtech innovation briefing [MIB8]: https://www.nice.org.uk/advice/mib8

3. National guidelines for allergic disorders from the British Society of Allergy and Clinical Immunology – BSACI (https://www.bsaci.org/) – BSACI Guidelines page (https://www.bsaci.org/guidelines/)

3.1. **Secondary Care Guidelines**

BSACI secondary care guidelines by the standards of care committee (socc)	***Year produced***	https://www.bsaci.org/guides-and-standards/bsaci-guidelines/
Pollen food syndrome/oral allergy	2022	**View Here**
Set-up of penicillin allergy de-labelling services by non-allergists working in a hospital setting	2022	**View Here**
Egg allergy	2021	**View Here**
Immunotherapy for allergic rhinitis 2017 update	2017	**View Here**
Peanut and tree nut allergy	2017	**View Here**
Adrenaline auto-injector	2016	**View Here**
Chronic urticaria and angioedema	2015	**View Here**
Beta-lactam / penicillin allergy	2015	**View Here**
Cow's milk allergy	2014	**View Here**
Venom allergy	2011	**View Here**
Drug allergy	2009	**View Here**
Anaphylaxis during general anaesthesia	2009	**View Here**
Resuscitation Council UK Emergency treatment of anaphylaxis: Guidelines for healthcare providers	2021	**View Here**

3.2. **Primary Care Guidelines** (BSACI have worked in partnership with primary care to develop specific guidance for primary care enabling appropriate referrals and care pathways with the majority of service users treated locally by their GPs)

BSACI primary care guidelines by the standards of care committee (SOCC)	***Year produced***	
Adrenaline auto-injector prescription for patients at risk of anaphylaxis: BSACI guidance for primary care	2023	**View Her**
Guidance on *Hymenoptera* venom allergy	2021	**View Her**
Guidance on milk allergy	2021	**View Her**
Guidance on the investigation of suspected anaphylaxis during anaesthesia	2018	**View Her**
Guidance on the management of allergy to penicillins and other beta-lactams	2020	**View Her**

3.3. **Clinical Practice Statements**

BSACI Clinical Practice Statements	***Year produced***	
Diagnosis and Management of Lipid Transfer Protein Allergy	2025	**View Her**

3.4. **Position Statements**

3.4.1. BSACI position statement on prescribing unlicensed medicines 26/06/2023: https://www.bsaci.org/bsaci-position-statement-on-prescribing-unlicensed-medicines/

3.4.2. BSACI position statement: Cost of living, health inequalities – and the adverse additional impact on children and young people living with allergic conditions 17/05/2023: https://www.bsaci.org/bsaci-position-statement-cost-of-living-health-inequalities-and-the-adverse-additional-impact-on-children-and-young-people-living-with-allergic-conditions/

3.4.3. BSACI statement: NICE approval of Palforzia, a treatment for peanut allergy in children and young people 29/04/2022: https://www.bsaci.org/bsaci-statement-nice-approval-of-palforzia-a-treatment-for-peanut-allergy-in-children-and-young-people/

3.4.4. BSACI Statement on the MHRA Guidance 10.12.2020 -managing allergic reactions following COVID-19 vaccination with the Pfizer/BioNTech vaccine: https://www.bsaci.org/bsaci-statement-on-the-mhra-guidance-10-12-2020/

3.5. **BSACI Standard Operating Procedures**

Standard operating procedures from the nurses in allergy committee	***Year produced***	
Omalizumab	2022	**View here**
Adrenaline auto injectors	2021	**View here**
Adult skin prick testing (spt)	2021	**View here**
Sublingual immunotherapy (slit)	2021	**View Here**

Subcutaneous immunotherapy (scit)	2019	View Here
Adult intradermal testing (idt)	2019	View Here
Paediatric skin prick testing	2019	View Here
How to use a nasal spray*	2023	View Here
Nasal douching	2017	View Here

4. **Guidance from the Royal College of Pathologists – use of laboratory allergy testing in primary care**
   4.1. Best practice recommendations Guidelines for the use of laboratory allergy testing in primary care – The Royal College of Pathologists: https://www.rcpath.org/static/a49f66cc-3c78-4ee7-97814c34a9d7d462/G194-BPR-Use-of-laboratory-allergy-testing-in-primary-care.pdf

5. **Guidelines from the British Association of Dermatologists on SJS/TEN and contact dermatitis**
   5.1. British Association of Dermatologists' guidelines for the management of Stevens-Johnson syndrome / toxic epidermal necrolysis in children and young people, 2018: https://doi.org/10.1111/bjd.17841
   5.2. U.K. guidelines for the management of Stevens–Johnson syndrome/toxic epidermal necrolysis in adults 2016: http://dx.doi.org/10.1016/j.bjps.2016.01.034
   5.3. British Association of Dermatologists' guidelines for the management of contact dermatitis 2017: https://doi.org/10.1111/bjd.15239

6. **Anaphylaxis Guidelines from the Resuscitation Council UK (https://www.resus.org.uk/)**
   6.1. Emergency treatment of anaphylactic reactions - Guidelines for healthcare providers: https://www.resus.org.uk/library/additional-guidance/guidance-anaphylaxis/emergency-treatment
   6.2. Vaccination-specific anaphylaxis guidance: https://www.resus.org.uk/about-us/news-and-events/anaphylaxis-guidance-vaccination-settings

7. **Guidelines on the management of hereditary angioedema**
   7.1. The international WAO/EAACI guideline for the management of hereditary angioedema—The 2021 revision and update: https://onlinelibrary.wiley.com/doi/full/10.1111/all.15214

8. **International Guidelines**
   8.1. **World Allergy Organisation – WAO (https://www.worldallergy.org/)** WAO Anaphylaxis Guidelines: https://www.worldallergy.org/education-programs/disease-focus; https://www.worldallergyorganizationjournal.org/article/S1939-4551(20)30375-6/fulltext
   8.2. **European Academy of Allergy and Clinical Immunology – EAACI** The EAACI produces a wealth of resources, including guidelines providing evidence-based recommendations for clinical practice, position papers,

	joint consensus documents; the newest position papers on every topic in allergy and asthma – available at https://hub.eaaci.org/resources/ **9. Transition Guidelines** 9.1. NICE Guideline NG 43: Transition from children's to adults' services for young people using health or social care services https://www.nice.org.uk/guidance/ng43 9.2. EACCI Guidelines on the effective transition of adolescents and young adults with allergy and asthma (2020) https://pubmed.ncbi.nlm.nih.gov/32558994/
8	**Appendices** **1. Information on mastocytosis and diagnostic criteria (Vienna consensus)** MCAS has different variants - as per Valent & Akin, J Allergy Clin Immunol Pract 2019;7:1109-14. DOI: https://doi.org/10.1016/j.jaip.2018.11.045. A European/US consensus group has established consensus criteria for the diagnosis of MCAS: the Vienna consensus criteria. These consensus criteria have been validated and are widely accepted in the Allergy scientific community (first published by Valent et al, Int Arch Allergy Immunol 2012;157:215–225; DOI: https://doi.org/10.1159/000328760 and recent review in Gülen et al. J Allergy Clin Immunol Pract 2021;9:3918-28; DOI: https://doi.org/10.1016/j.jaip.2021.06.011). The definition of MCAS after the Vienna consensus is based on three diagnostic criteria, all of which have to be fulfilled before the diagnosis of MCAS can be established: 1. the episodic (recurrent) occurrence of typical clinical symptoms/signs of severe, acute, systemic (involving at least two organ systems) mast cell activation - that is, that are produced by mast cell mediators (often in the form of anaphylaxis); 2. an increase in mast cell mediators, preferably serum tryptase levels by at least 20% over the individual tryptase baseline plus 2 ng/mL absolute tryptase within a 3-4-hour window after the reaction; and 3. a substantial (documented) response of the symptomatology to therapy with MC-stabilising agents, drugs directed against MC mediator production, or drugs blocking mediator release or effects of MC-derived mediators (e.g., histamine receptor blocker).

Change form for published Specifications and Products developed by Clinical Reference Group (CRGs)

Product name: Specialist Allergy Services (Adults)
Publication number: B09/S/b
CRG Lead: Blood & Infection Clinical Lead

Description of changes required

Describe what was stated in original document	Describe new text in the document	Section/Paragraph to which changes apply	Describe why document change required	Changes made by	Date change made
Format change: the content of the original service specification has been transferred into the updated NHS England Specialised Service Specification Template. As a result, some sections have been removed in line with guidance to make service specifications shorter, more precise and therefore more accessible.	Formatting changes throughout the document	Throughout	A new service specification template was published in 2022	SWG	May 2023 – March 2025
Service: Specialised Allergy Services (All Ages)	Service name: Specialist Allergy Services (Adults)	Service / Service name	Service name updated to reflect the Prescribed Specialised Services Manual and to avoid confusion with the published service specification for Paediatric Medicine: Specialised Allergy Services	SWG	May 2023 – March 2025

Allergic diseases are amongst the most common diseases of Western Society affecting up to 30% of the UK population (20 million) at some time in their lives. For the majority of patients (95%) these allergic diseases can be managed by primary or other non-specialist allergy services with routine therapies (e.g. topical (ointment, inhaler, nasal spray) steroids, antihistamines) coupled with advice (e.g. information regarding natural history, avoidance strategies, allergy management plans). A Specialist Service is however required for management of rare, severe or complex multisystem allergic disease as described below. The specialist service will provide the service for the top tier of complex and severe allergy, and the rest of the allergy service will be by provision through local commissioning arrangements. Approximately 5% of patients with allergies are suitable for CCG commissioning, leaving approximately 0.1% (20,000) requiring referral to a specialist centre with half of those currently receiving specialist interventions such as immunotherapy or investigation for drug allergy.	Specialist allergy services provide services for adults with severe allergic conditions or those who have common allergic conditions for which conventional management has failed and for whom specified specialist investigations and treatments are required. Specialist allergy services are provided by multidisciplinary teams, led by physicians with evidence of training and/or experience in the practice of allergy or immunology. An estimated 20 million people in the UK – a third of the population – have an allergy related disorder, although only a proportion will have allergic disease of sufficient complexity to require specialist opinion or management.	1.1 National/local context and evidence base / 5.2 Minimum Population Size	New template and to only include figures which can be evidenced	SWG	May 2023 – March 2025
Remainder of 1.1 National/local context and evidence base	None	1.1 National/local context and evidence base	National/local context and evidence base section not required in new template	SWG	May 2023 – March 2025

The provider shall ensure that Specialist Allergy centres provide: • A high quality, accessible and sustainable service for patients with severe and complex allergies that meets the needs of the local population and reflects effective resource use and incorporates the views of patients. • Excellent, holistic, multidisciplinary care for patients with allergic diseases according to best practice guidelines defined by authoritative bodies, accredited or working towards accreditation through national accreditation organisations. • The expertise required for the investigation, clinical assessment, treatment and management of patients with suspected and established allergic diseases. • Equity of access to best practice standards, based on current guidelines for diagnosis and management for patients with allergic diseases and related complications. • Integrated care with primary, secondary and other care providers and ensure close links with other expert centres at national and international levels. The provider shall address individual needs for control of allergy, including self-administration/home therapy and (when indicated) desensitisation immunotherapy.	Specialist allergy services deliver high quality, multi-disciplinary specialist care to adults with severe and complex allergies. They aim to reduce morbidity and mortality from causes considered preventable and improve the experience and health-related quality of life (QoL) of service users with allergic and related conditions. The above aim will be achieved by: • Delivering the expertise required for the investigation, clinical assessment and management of service users with suspected and established allergic diseases; • Integrating care with primary, secondary, and other care providers with particular emphasis on supporting care provision through primary care;	2.1 Aims and objectives of service / 6.1 Service aims	Amended to make more succinct and reflect feedback from clinicians and service users on key aims	SWG	May 2023 – March 2025

The service will deliver the aim to improve both life expectancy and quality of life for adults and children with allergy by: • Preventing acute and chronic allergic symptoms. • Halting the progress of complications if present and where possible. • Reversing previous psychological damage and disability when possible. • Recognising complications early and managing them optimally, particularly those not amenable to first line therapy. • Delivery of safe and effective allergen immunotherapy and avoiding complications of immunotherapy. • Developing approaches to management, based on individual needs, for the lifelong management of allergic disease, including self management/home therapy when possible.	• Promoting prevention strategies, optimising early management of complications, preventing disease progression and reversing previous psychological damage and disability when possible; • Delivery of safe and effective curative or disease modifying treatments (for example allergen immunotherapy) where indicated and avoiding complications of treatment; • Developing approaches for the successful lifelong management of allergic disease, including self-management/home therapy; • Delivering care holistically, ensuring that all service users have access to a wide range of specialist				

	multi-disciplinary services; • Delivering treatment and care that conforms to UK/European standards and published clinical guidelines; • Maintain close links with other expert centres at national and international levels; • Working with relevant stakeholders and service user support initiatives.				
2.2 Service description/care pathway	Specialised patient pathway separated into Diagnosis and Treatment and monitoring	2.2 Service description/care pathway / 7.2 Pathways	Additional clarity	SWG	May 2023 – March 2025
• Adequate clinical space in relation to the number of patients being treated.	• Adequate staffing and clinic space for regular face-to-face and remote outpatient clinics for assessment and follow-up. The service must have the capacity to review service users in a dedicated allergy clinic	2.2 Service description/care pathway / 7.2 Pathways	Specify importance of face-to-face clinics, as well as remote	SWG	May 2023 – March 2025

	face-to-face when clinically indicated;				
• Access to an appropriately staffed day-case facility that can provide immunotherapy and Biologic infusions. This service should be supported by clear guidelines, protocols, and pathways for patient care.	• Access to an appropriately staffed designated day case unit where food/drug challenges and desensitisation, drug skin testing, commissioned/NICE approved immunotherapy and biologic/novel treatments can be provided. Staff within the unit should be working to national and international guidelines and IQAS standards;	2.2 Service description/care pathway / 7.2 Pathways	To reflect current guidelines	SWG	May 2023 – March 2025
The provider shall ensure that management of those allergies requiring other/new treatments (e.g. monoclonal antibodies or cytokines) on a named patient basis, where there is a suitable evidence base. This includes day case attendance, nursing supervision, the drug, pumps for subcutaneous or intravenous use, monitoring by biochemical tests, specialised immunopathological tests and medical follow-up.	None	2.2 Service description/care pathway	Duplication of content	SWG	May 2023 – March 2025
The provider shall ensure that the Adult Specialist Allergy services should be provided by a multi-disciplinary team that includes:	Specialist allergy services will be delivered by a multi-disciplinary team due to the	2.2 Service description/care pathway / 7.4	Additional clarity and to specify importance of access to pharmacists	SWG	May 2023 – March 2025

• At least two Consultants in Allergy or equivalent with experience/training in the management of patients with complex/specialised allergy as described above and who maintain up-to-date Allergy CPD in their area of practice. • Physicians, dieticians and nurses trained in Allergy or who have had long specialist experience in the practice of Allergy and who maintain up-to-date Continuing Professional Development in Specialised Allergy (CPD). • There should be no single handed practice unless fully supported by network governance structures and regular MDT/network meetings.	complex nature of the conditions. This must include: • At least two Consultants* in Allergy or Allergy and Clinical Immunology on the specialist register for allergy or immunology or with evidence of equivalent experience/training in the management of service users with complex/specialist allergy as described above. These Consultants must maintain up to date Continuing Professional Development (CPD) in specialist allergy; • At least two allergy specialist nurses*; • Access to the following allied health professionals: ○ Dieticians, ideally who have training or specialist experience in the practice of allergy;	Essential staff groups	(not in original document) and inclusion of anaesthetist		

	○ Clinical psychologists, ideally with expertise in allergic conditions and wherever possible embedded within the service; ○ Speech and language therapists; ○ Lung physiologists; ○ Pharmacists. • Access to social workers as required; • Investigation of perioperative anaphylaxis should include an anaesthetist within the multi-disciplinary team, with a minimum of at least 20 referrals per annum. * Services should not be organised around a single-handed consultant or specialist nurse model unless fully supported by network governance structures including cover for leave, weekly MDTs and regular network meetings, as well as				

	all other requirements outlined in this document.				
There is documented consent and risk assessment before initiating treatment with blood products including C1 inhibitor.	None	2.2 Service description/care pathway	Pathways for treatment with C1 inhibitor covered under specialist immunology specification	SWG	May 2023 – March 2025
The provider shall provide transition services: • For children with complex allergy before referral to adult services based on the framework recommended by the Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083592 • Transfer arrangements and preferences should be discussed with the child and their family up to 12 months in advance. Shared protocols between child and adult services should be established.	All healthcare services are required to deliver developmentally appropriate healthcare to service users and families. Children and young people with ongoing healthcare needs may be required to transition into adult services from children's services. Transition is defined as a 'purposeful and planned process of supporting young people to move from children's to adults' services'. Poor planning of transition and transfer can result in a loss in continuity of treatment, service users being lost to follow up, service user disengagement, poor self-management and inequitable health outcomes	2.2 Service description/care pathway / 7.2 Pathways	Updated with generic wording on Transition and specific requirements added for clarity	SWG	May 2023 – March 2025

	for young people. It is therefore crucial that adult and children's NHS services, in line with what they are responsible for, plan, organise and implement transition support and care (for example, holding joint annual review meetings with the child/young person, their family/carers, the children's and adult service). This should ensure that young people are equal partners in planning and decision making and that their preferences and wishes are central throughout transition and transfer. NICE guidelines recommend that planning for transition into adult services should start by age 13-14 at the latest, or as developmentally appropriate and continue until the young person is embedded in adult services. Specialist allergy services should have formalised arrangements for transition care including:				

	• A named adult allergy consultant in every tertiary centre as designated transition lead; • The adult allergy transition lead or nominated adult allergy team member will engage with paediatric counterparts for pathway and resource development for appropriate transition to adult services (including involvement in any transition documents and resources such as Ready-Steady-Go templates, transition checklist, comprehensive transition letter, joint transition clinic where appropriate).				
The provider shall maintain the following links: Secondary care links: • Depending on the nature of the allergic disease, services are involved in shared care in relation to general medical needs, delivery of drugs.	Service users with complex allergy will often be managed by a multi-disciplinary team including ENT, respiratory medicine, gastroenterology, haematology, immunology	2.2 Service description/care pathway / 7.2 Pathways	Revised wording to fit with shared care arrangements section of new template	SWG	May 2023 – March 2025

• Secondary providers will be integrated with well-defined service delivery specifications and referral pathways linked within the network Primary care links: • Care plans of allergy patients are shared with primary care. • Home therapy and management is arranged in liaison with CCGs. • Clinic letters are sent to GPs and other specialties involved in a patient's care.	and dermatology, with specialist allergy nurses, allergy dieticians, allergy psychologists and laboratory diagnostic support providing comprehensive management. Where services are best delivered through joint-speciality clinics (e.g. with severe multi-system allergic or severe asthma, severe eczema disease), these clinic designs should be used. Care plans and clinic letters should be shared with primary care and other specialities involved in the care of the service user.				
Referrals can be made from both primary and secondary care as follows: • Due to the complex nature of severe allergies, tertiary referrals come from secondary care centres (general physicians) or other tertiary or specialist physicians (particularly dermatology, respiratory, ENT, gastroenterology and accident and emergency). • Primary Care Physicians (Tier 1) shall refer patients directly to the service when	Referrals for service users presenting with the conditions listed in 7.1 above come from primary care, accident and emergency departments and secondary/tertiary hospital settings. All referrals should be triaged by a member of the specialist team to ensure the referral requires specialist input. A care pathway with	2.2 Service description/care pathway / 7.2 Overall patient pathway	More concise	SWG	May 2023 – March 2025

standard approaches to management fail or the patient meets specialist referral criteria, though these cases will require screening by the centre to ensure the referral requires specialist input or can be managed through CCG commissioned local or regional allergy services which may be provided for the local population by the same facility. A care pathway with referral guidance should be developed.	referral guidance and advice and guidance should be developed using existing NHS platforms.				
Equity of access to services • No patient should have to travel excessively for access to local expert centres. • Patients with rarer diseases requiring referral to a national specialist centre or centres should have equitable access and distance to travel wherever possible, taking account of geographical issues. • Some centres provide specialist services to other health economies (Wales, Scotland, Northern Ireland, Republic of Ireland).	None	2.2 Service description/care pathway	Not required in new template	SWG	May 2023 – March 2025
Location(s) of Service Delivery At present, there are approximately 50 services in the UK currently providing specialist allergy services as described. 31 adult allergy centres in England and Wales (17 staffed by immunologists) and 19 paediatric centres (7 of which are staffed by paediatric immunology specialists and 12 by paediatric allergy specialists and some of which are co-located with the adult service). (Royal	None	2.2 Service description/care pathway	Not required in new template	SWG	May 2023 – March 2025

Colleges of Physicians Report 2010 http://www.nelm.nhs.uk/en/NeLM-Area/News/2010---June/24/Allergy-services-still-not-meeting-the-unmet-need-Joint-report-of-RCP-and-RCPath-Working-Party-June-2010/). There will be approximately 20,000 new referrals of patients with adult allergic disease of sufficient complexity to require specialist opinion or management in England.					
• The provider shall ensure that services are available during office hours. • The provider shall ensure that there is a written agreed patient pathways for dealing with out of hours emergencies and a system for giving out-of-hours advice, particularly in relation to advice on matters such as anaphylaxis, drug, latex and anaesthetic allergy.	The Provider must ensure that services are available Monday to Friday from 09:00 to 17:00. The Provider must ensure that pathways for out of hours access to appropriate emergency care are locally agreed and that service users are aware of the arrangements. Services should work collaboratively with urgent care services to provide guidance for the management of users of the specialist allergy service should they present acutely.	2.2 Service description/care pathway	Additional clarity and to specify importance of service users being aware of how to access care out of hours	SWG	May 2023 – March 2025
Response time & detail and prioritisation	None	2.2 Service description/care pathway	Not required in new template	SWG	May 2023 – March 2025

• The provider shall ensure that centres will provide (in collaboration with patient organisations where they exist): ○ written disease-specific information leaflets ○ periodic educational events for patients ○ periodic educational events for GPs ○ information to patients and staff about patient support organisations • The provider shall ensure that Specialist Centre Staff support patient groups with membership of Medical Advisory panels. • The provider shall ensure that where possible patient information should be standardised nationally or across networks. National guidelines and patient information in many areas of allergy have already been developed by BSACI and the Anaphylaxis Campaign to harmonise care. http://www.bsaci.org/index.php?option=com_content&task=view&id=117&Itemid=1 http://www.anaphylaxis.org.uk • Shared protocols and guidelines have already been developed in professional networks and in some multi-centre regional groups http://www.ukpin.org.uk/home/to harmonise care and should be used to underpin policy development with patient group involvement. Patient organisations have a large resource of information sheets which could be adapted and adopted in collaboration.	The Provider should offer (in collaboration with service user organisations where they exist): • Written disease-specific information leaflets; • Periodic educational events for service users; • Periodic educational events for GPs; • Information to service users and staff about service user support organisations.	2.2 Service description/care pathway	More concise	SWG	May 2023 – March 2025

The service outlined in this specification is for patients ordinarily resident in England*; or otherwise the commissioning responsibility of the NHS in England (as defined in Who Pays?: Establishing the responsible commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges). *Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England. Specifically, this service is for adults with allergic disease requiring specialised intervention and management, as outlined within this specification.	This service specification relates to adults aged 18 years and over. Young people aged 16 or 17 years old can receive developmentally appropriate care in adult specialist allergy services.	2.3 / 5.1 Population covered	New template guidance and to provide clarity regarding treatment of 16 and 17 year olds.	SWG	May 2023 – March 2025
Individuals requiring specialist allergy services would be characterised by: • Increased risk of death because of severity of the allergy (anaphylaxis, angioedema, drug allergy, brittle asthma). • Persisting poor quality of life despite routine therapies with restrictions to daily activities at home, school work (severe eczema / atopic dermatitis) with a major allergic component, asthma, hay fever (allergic rhinoconjunctivitis) and chronic urticaria.	Individuals requiring specialist allergy services would be characterised by: • Increased risk of death because of severity of the allergy; • Persisting poor quality of life despite routine therapies with restrictions to daily activities at home	2.4 Any acceptance and exclusion criteria / 7.1 Service model	Additional clarity and to specify importance of access to allergen immunotherapy	SWG	May 2023 – March 2025

• Requirement for safe allergen immunotherapy: Immunotherapy has been reintroduced into the UK with tighter controls and recommendations and should only be performed by experienced health care professionals in specialised centres with direct access to resuscitation facilities (CSM Update – desensitising vaccines, Br Med J, 1986).	and/or at work including those with severe allergic rhinoconjunctivitis, chronic urticaria, severe eczema/atopic dermatitis with a major allergic component (managed in collaboration with dermatology services) and with allergic asthma (in conjunction with respiratory services); • Rare diseases leading to allergic symptoms requiring complex investigations and therapies (mastocytosis, hereditary angioedema, eosinophilic enteropathies and other hypereosinophilic diseases). • Diseases with allergic symptoms but where the cause is unclear (idiopathic) and specialist input is				

	required to make a specific diagnosis, identify triggers, optimise management and prevent further recurrences. Specialised services should provide access to all commissioned treatments for allergic disease including licensed allergen immunotherapy. Subcutaneous immunotherapy should only be performed by experienced health care professionals in specialised commissioned allergy centres with direct access to resuscitation facilities. Sublingual immunotherapy (SLIT) should be initiated in specialised commissioned allergy centres or by other secondary care services with appropriate expertise to manage patients with allergic disease, with shared care agreements involving primary care for ongoing treatment.				

List of conditions to be provided by specialist allergy services and exclusion criteria	Updated list of conditions to be assessed and managed in specialist allergy centres and exclusion criteria	2.4 Any acceptance and exclusion criteria / 7.1 Service model	Additional detail provided for greater clarity and to reflect the Prescribed Specialised Services Manual and more recent guidelines	SWG	May 2023 – March 2025
2.5 Interdependencies with other services	Microbiology, rheumatology, anaesthetics, clinical genetics and maternity services added.	2.5 Interdependencies with other services / 7.6 Interdependent service components – links with other NHS services	To reflect current practice	SWG	May 2023 – March 2025
3 Applicable Service Standards	7.9 Links to other key documents	3 Applicable Service Standards / 7.9 Links to other key documents	References updated	SWG	May 2023 – March 2025
The provider shall ensure that the service participates in IQAS Allergy Accreditation or future Paediatric equivalent, initially by registering and working towards full accreditation. Accreditation shall eventually be mandatory for Specialist Centres. The scheme is called Improving Quality in Allergy Services (IQAS) (http://www.rcplondon.ac.uk/resources/improving-quality-allergy-services-iqas-registration-scheme)	All centres should be registered and actively working towards or have achieved accreditation through the Royal College of Physicians Improving Quality in Allergy Services (IQAS) programme. Centres that are not yet accredited must have a Trust action plan demonstrating progress	3.1 Applicable national standards / 6.2 Outcomes	Updated to reflect current accreditation programme	SWG	May 2023 – March 2025

The provider shall ensure that Centres shall be active members and participants of a UK Accreditation Scheme (IQAS or future Paediatric equivalent) as evidenced by: • Full registration of the Centre within a specified timeframe informed by a gap analysis and action plan. • If accreditation has not yet been achieved, Centres should be actively working toward accreditation. • Patient information should be standardised nationally or within each network • Where HAE care is provided the centre will register to accredit the service to UKPIN (UK Primary Immunodeficiency Network, http://www.ukpin.org.uk/home/accreditation-standards.html) standards as defined in the Immunology Specialist Service specification.	towards accreditation. Accreditation involves evaluating a service against a set of standards to promote a culture of continuous improvement, thereby providing assurance to service users, referrers and commissioners about the quality of the service provided.				
4 Key Service Outcomes	6.2 Outcomes	4 Key Service Outcomes / 6.2 Outcomes	Updated in line with QNT approach to quality outcomes and metrics development	SWG	May 2023 – March 2025
A minimum attendance requirement at 50% of network meetings (from a minimum of 4 meeting per annum per network) will be necessary.	There should be clinical representation from all staff groups at all network meetings (a minimum of three meetings should be held per annum per network).	4 Key Service Outcomes / 7.3 Clinical Networks & 7.4 Essential Staff Groups	To reflect current practice	SWG	May 2023 – March 2025

	All medical and nursing staff should attend at least two network meetings per annum.				
• The provider shall ensure that all services in a network share and compare their dashboard performances in a process of continuous quality improvement. The dashboard elements to be defined by the Immunology and Allergy CRG but to include: ○ Engagement and communication with GPs ○ Involvement of patients in their care	None	4 Key Service Outcomes	Network and SSQD requirements already covered elsewhere in specification	SWG	May 2023 – March 2025
Coding and Activity monitoring	None	4 Key Service Outcomes	Not required in new template	SWG	May 2023 – March 2025
Location of Provider Premises	None	5 Location of Provider Premises	Not required in new template	SWG	May 2023 – March 2025
None	Health inequalities statement Services should be organised on a population health basis with a clear referral and treatment pathway to ensure that people with suspected or diagnosed allergic conditions: have equitable access to specialist allergy outpatient and inpatient services for the purposes of diagnosis and management;	7.1 Service Model	Outline provider responsibilities regarding equity of access	SWG	May 2023 – March 2025

	• have equitable access to specialist allergy outpatient and inpatient services for the purposes of diagnosis and management; • have equitable access to commissioned treatments for allergic conditions; • have care provided as close to home as possible, with appropriate governance and oversight where necessary from multi-disciplinary teams linked to a specialist allergy centre; • have access to clinical trials and research in an equitable manner through engagement with Clinical Research Networks. Services must: • identify which populations currently experience inequitable				

	access with particular reference to deprivation, ethnicity and inclusion health groups; • identify barriers to access at service level for these populations; • implement inclusion measures to improve equity. Wherever any component of the core service specification cannot be delivered at a specialist allergy centre, arrangements should be put in place with other providers of that specialist service to ensure service users continue to have equitable access to treatment.				
None	• Access to anaesthetic expertise in the investigation of perioperative allergy (e.g. joint clinic or involvement of an anaesthetist as part of a multi-disciplinary approach);	7.2 Pathways	Specify importance of access to anaesthetic expertise (stakeholder testing feedback)	SWG	May 2023 – March 2025

None	• Access to a comprehensive assessment of the upper airway for service users with resistant rhinitis, including a clearly defined referral pathway for patients with upper-airway asthma mimics (e.g. laryngeal dysfunction);	7.2 Pathways	Specify importance of access to upper airway assessment (stakeholder testing feedback)	SWG	May 2023 – March 2025
None	[Treatments] include: • Immunotherapy (licensed and commissioned treatments should be offered) for inhalants and Hymenoptera venom allergy– hospital-based injected allergen and home-based treatment via oral or sublingual immunotherapy or other routes. This includes treatment initiation, maintenance and follow-up care; • Immunotherapy for food allergy - hospital-	7.2 Pathways	Clarity regarding treatments provided	SWG	May 2023 – March 2025

	and home-based allergen treatment via oral, sublingual, epicutaneous immunotherapy or other routes. This includes treatment initiation, maintenance and follow-up care; • Drug desensitisation; • Commissioned/NICE approved biologics and novel therapies.				
None	• Access to urgent allergy review where clinically indicated e.g. allergy assessment during pregnancy and when urgent treatment is required;	7.2 Pathways	Specify importance of access to urgent review	SWG	May 2023 – March 2025
None	• Written information for service users and other healthcare providers involved in their care detailing their diagnosis, treatment and monitoring plan.	7.2 Pathways	Specify importance of care plan being provided to service users	SWG	May 2023 – March 2025
None	Specialised allergy services should enable shared care with other allergy services and with primary care, for example	7.2 Pathways	New section in template	SWG	May 2023 – March 2025

	for SLIT for allergic rhinitis/rhinoconjunctivitis. Appropriate training and governance arrangements should be led by specialised allergy services in order to facilitate formal shared care agreements as follows: • The provision of SLIT through these agreements should be initiated in specialised commissioned allergy centres or by other secondary care services with appropriate expertise to manage patients with allergic disease. Service user monitoring and prescribing can be transferred to local hospitals/primary care once service users have been treated without reactions/side effects and their SLIT dose has been optimised and stabilised;				

	• The initial treatment, up-dosing where applicable and initial maintenance dose must be prescribed by the initiating specialist; • Specialised centres should ensure specialist input is available in order to determine duration of treatment, dose or formulation adjustments, frequency of review and decision to terminate treatment.				
Reference to clinical networks throughout document	7.3 Clinical Networks	7.3 Clinical Networks	New section in template	SWG	May 2023 – March 2025
Reference to facilities throughout document	7.5 Essential equipment and/or facilities	7.5 Essential equipment and/or facilities	New section in template	SWG	May 2023 – March 2025
None	8 Appendices	8 Appendices	To provide information on Mast Cell Activation Syndrome (MCAS) to support specialist allergy teams	SWG	May 2023 – March 2025